Different Like Me, Inc.

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1200 NW 17th Avenue, Delray Beach, FL 33486
Phone (561) 270-2280

Consent for Treatment

I, _____ give consent for treatment for my child _____. I have been informed of the nature and purpose of evaluation and/or treatment.

I understand that during treatment, the above-named, patient, a minor will disclose confidential information about himself/herself that is crucial to the therapeutic process and for which the client has asked Different Like Me Inc. staff to maintain his/her confidence. I agree that Different Like Me Inc. staff will not disclose to the legal guardian such information unless the child is at risk of harming himself/herself or others, or it is otherwise clinically, ethically and or legally appropriate to make such disclosure to the legal guardian.

I understand that I am responsible to pay for services at the time they are rendered. Different Like Me Inc. does not participate or accept any assignment of medical or mental health benefits other than Medicare.

I have read, understand, and consent to all of the conditions stated above. Furthermore, I assert that I am the legal guardian of the above-named client and that as such, I have the right to client's consent for treatment and that additional signatures are not required.

_____

Parent/Guardian Signature Date

I have witnessed the signature of the legal guardian.

_____

Witness Signature Date

Different Like Me, Inc.

IMPORTANT INFORMATION AND CONSENT FOR TREATMENT

Thank you for choosing this service. This sheet describes some details about our professional relationship. If there is anything you do not understand please ask me and I will be happy to discuss it with you.

Appointments and Fees

Fees for service are payable at the time of each visit, unless other payment arrangements have been established. You are responsible for the annual deductible and any percentage of the fee not covered by your insurance plan. We will gladly fill out any insurance claim forms for you so that *you* can be reimbursed. Your appointment time is reserved just for you. You are responsible for the full fee for all scheduled appointments, and ***will be charged for any canceled appointment unless you notify us at least 24 hours in advance***. There is a $30.00 bank charge fee for any returned check.

Confidentiality

We are committed to protect your privacy and confidentiality to the fullest extent possible in accordance with the Federal Health Insurance Portability and Accountability Act (**HIPAA**) and Florida Laws 491.0147 and 394.459 and Title 42 of the Code of Federal Regulations (chemical abuse/drug addiction).
You will have an opportunity to receive the Notice of Privacy Practices under **HIPAA.**

Communication with clients and clients' communication with his/her therapist is considered privileged communication under the law. No disclosure of information about a client, current or past, may be released to any person or agency without a written consent for release of information properly executed and signed by the client. This rule applies equally to both written and oral communications.

The current state laws and regulations limit confidentiality and require disclosure under the following circumstances: (1) A receipt of a valid court order. (2) If there is any suspicion of physical, sexual, or emotional abuse and/or neglect of a child, we are required by law to inform the Florida Department for Families and Children. We are also required by law to inform Adult Protective Services, Department of Elder Affairs, if there is any suspicion of physical abuse of a dependent adult. (3) If we have a reasonable cause to believe that you are a danger to yourself or to the person or property of someone else, then disclosure must be made to an appropriate individual or agency that can prevent the threatened danger. The written case record is kept for seven years and is then destroyed by shredding.

Insurance Assignment and Consent for Treatment

By signing below you are authorizing the release of any necessary information about your case to your primary and, if applicable, secondary insurance or Medigap company to process your insurance claim. You are also assigning benefits to Different Like Me, Inc. for any eligible payments from any insurance carrier, including Medicare and Medigap. This is a direct assignment of the rights and benefits under the insurance policy. You agree to pay any balance due over insurance payments. You understand that you do not need to provide your supplemental insurer with information concerning your Medicare claim, because signing this authorization will cause Medicare payment to cross over automatically. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand the above, and agree to engage your professional services under these terms and conditions.

*(Print Name)*_____ *DOB:*_____

(Signature)_____ *Date:* ____/____/____

Different Like Me, Inc.
Authorization For Disclosure

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____, authorize Different Like Me, Inc. to disclose to and/or obtain from:

_____

_____

_____ the following information:
[Insert Name of Person or Title of Person or Organization and contact phone or address]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Speech/Cognitive Therapy Notes
(Evaluations, TX, and Progress Notes)

_____ Therapy and Treatment Notes
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
*(*Cannot be combined with any other disclosure)*
_____ Summary of notes
_____ Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than stated above, please specify:

_____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Different Like Me, Inc. at 1200 NW 17th Ave. Suite 12, Delray Beach, FL 33445. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date 1 year or as otherwise indicated:_____

Conditions

I further understand that Different Like Me, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: Unable to release records

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

(Parent, Guardian or Personal Representative Name if not signed by patient)

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date

Different Like Me

Failure to Cancel/ No Show

Patients Name: _____ Date of Birth: _____

I understand that if I fail to attend a scheduled appointment, and fail to cancel the appointment within one full business day prior to the scheduled appointment, I will be responsible for the full fee for all scheduled appointments. Insurance will not reimburse me for this expense nor will Different Like Me Inc bill my insurance for this expense.

I hereby agree to pay the no-show fee as set forth above.

_____

Signature of Patient Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

Witness' Signature: _____

1200 NW 17th Avenue, Suite 12, Delray Beach, FL 33445 Phone: (561) 270-2280 Fax: (561) 270-2284
E-Mail: alysenovember@differentlikeme.com Web: www.differentlikeme.com

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name_____ Date of Birth: _____

Please indicate how you would like staff from Different Like Me, Inc. to contact you. Unless specified below, we will attempt to make contact utilizing any information you have provided to us. Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection except if an emergency arises.

Please contact me as indicated below:

Cell# _____Home # _____

Work # _____ Email: _____

Mail/Address: _____

_____

_____**You may leave a message on any phone number listed above**

_____You may leave a message with (Names) _____

_____ _____

Signature of Patient or Legal guardian Date

_____

Name of legal guardian signing this form if other than patient

Approved: _____ _____

Signature of Staff Date

1200 NW 17th Avenue, Suite 12, Delray Beach, FL 33445 Phone: (561) 270-2280 Fax: (561) 270-2284

E-Mail: alysenovember@differentlikeme.com Web: www.differentlikeme.com

Different Like Me, Inc.
1200 NW 17th Ave, Suite 12
Delray Beach, FL 33445
561-270-2280

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Different Like Me, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Different Like Me, Inc.

_____

Signature of Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Client Refuses to Acknowledge Receipt:**

_____

Therapist Signature **Date**

Different Like Me, Inc. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious

threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer Alyse November at 1200 NW 17th Ave, Suite 12, Delray Beach, FL 33445:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will

accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Alyse November at 1200 NW 17th Ave. Suite 12, Delray Beach, FL 33445 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.